Comparative POC

POC Accepted 3/26/2012

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445494	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RHEA COUNTY	7824 RHEA COUNTY HWY DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Comparative Federal Life Safety Code (LSC) Survey was conducted on February 28, 2012. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. This building was Type II (000), partially sprinklered and housed 89 beds. On the day of survey, census was 83. The deficiencies determined during the survey are as follows:	K 000	This plan of correction is the facility's Credible allegation of compliance. Preparation and/or execution of this Plan of correction does not constitute Admission or agreement by the provider Of the truths or facts alleged or Conclusions set forth in the statement Of deficiencies. The plan of correction Is prepared and/or executed solely because It is required by the provisions of federal And state law.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide a fully protected type of construction in the building. The findings included: Approximately at 3:15 PM, it was observed that 24'x20' combustible overhang located at the front entrance did not have sprinkler coverage. This deficient practice affected 4 people. This was verified with a member of the maintenance staff at the time of discovery..	K 012	1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice? A contract vendor added flame retardant (F-1) paint, and approved covering to the Existing overhang located at the front Entrance on 3/23/12. The structure Will be made of a fully protected type Of construction. 2) How will you identify other residents Having the potential to be affected by the same deficient practice? The Director of Maintenance confirmed On 3/16/12 that no other overhangs are Located on the facility premises. The Existing overhang will be made of a fully Protected type of construction by 3/23/12. 3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur? The Director of Maintenance will complete A review of the existing overhang located at The front entrance monthly to determine that The construction type and height remains fully Protected.	3/23/12 3/23/12 3/23/12
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kate Swafford

TITLE: ED

(X5) DATE: 3/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide a fully protected type of construction in the building. The findings included: Approximately at 3:15 PM, it was observed that 24'x20' combustible overhang located at the front entrance did not have sprinkler coverage. This deficient practice affected 4 people. This was verified with a member of the maintenance staff at the time of discovery..	K 012	4) How will the corrective action be Accomplished for those residents found to have been affected by Deficient practice? The Director of Maintenance will present The findings of the monthly overhang review to the Performance Improvement Committee monthly for three consecutive months. The Performance Improvement Committee consisting of the Executive Director, Medical Director, Business Office Manager, Staff Development Coordinator, Wound Care Nurse, Director of Medical Records, Director of Environmental Service, Director Of Maintenance, Director of Social Services, Director of Human Resources, Director of Rehab Services, Director of Activities, Director of Nursing Director of Food and Nutrition Services, and Director of Admissions/Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	3/23/12
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kate Swafford — TITLE: ED — (X6) DATE: 3/20/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	Continued From page 1 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: It was determined by record review and staff interview that the facility failed to maintain the fire alarm system according to NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code in terms of frequency of testing. The findings included: Approximately at 4:00 PM, review of the safety system records and interview of the Maintenance Director indicated that the fire alarm system was last tested on 12/30 /11. It was also observed that several smoke detectors were not checked during the test. This deficient practice affected 5 residents. This was verified with maintence staff at the time of discovery.	K 052	1) What corrective action will be accomplished for those residents found to have been affected by The deficient practice? A contract vendor tested the fire alarm System on 3/13/12, including facility Smoke detectors. The system has a maintenance and testing program in place with proper frequency. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Director of Maintenance confirmed with a contract vendor on 3/13/12 that the fire alarm system, including the facility smoke detectors, were tested and no issues were found. 3) What measures will be put into place or what systematic changes will you make to ensure that the deficient practices will not recur? A contract vendor will test the fire alarm System annually, including the smoke detectors In the facility. This test is scheduled to occur In 03/2013.	3/23/12 3/23/12 3/23/12

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